Washington State Employee Assistance Program

Seattle (206) 281-6315 ○ **Olympia (360) 753-3260** ○ **Statewide (877) 313-4455**
Seattle FAX (206) 281-6319 ○ **Olympia FAX (360) 664-0498** ○ **Statewide Fax (360) 664-0498**

Authorization for Use or Disclosure of Protected Health Information

I, _____, authorize Washington State EAP, to disclose to the following agency, provider or individual.

Name Position

Telephone Address

The purpose of this disclosure is for the specific purpose of: my work performance_____, treatment planning_____case management_____, Other _____

_____.

I understand that my records are protected under Federal Regulation 42 CFR, Confidentiality of Alcohol and Drug Abuse and under state (Health Care Information Act) Confidentiality Regulations and cannot be disclosed without written consent, except as a specifically stated by the law.

I understand that, under the law, my records may be released without my consent when the EA professional believes in her/his judgment that danger to self or another, child or elder abuse, or abuse of developmentally disabled persons exists; potential damage to property; or to comply with a court order.

This authorization expires in ninety (90) days from today's date unless I expressly revoke my consent earlier than that date. My consent for disclosure is subject to my express revocation at any time prior to the above condition, event, or date, except to the extent that any action has been taken by EAP in reliance upon my authorization.

Printed name of *client*

Signature of client Date:

Signature of EA Professional Date:

HR State of Washington Employee Assistance Program